NOVA SCOTIA'S FRAMEWORK FOR ACTION ON HIV/AIDS

Produced by the
Provincial HIV/AIDS Strategy Steering Committee

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Executive Summary

For more than 15 years, HIV/AIDS has been an important issue in Nova Scotia and throughout the country. In 1993, the provincial government introduced an HIV/AIDS strategy for Nova Scotia. As the reality of the HIV/AIDS epidemic in Nova Scotia had changed, it was recognized that a renewed strategy was necessary. In 1997 the Nova Scotia Advisory Commission on AIDS (NSACA) initiated discussions about the need for a revised provincial strategy. A steering committee was formed and a consultant was hired to collect information from Nova Scotians about how to respond to HIV/AIDS in Nova Scotia.

More than 200 people participated directly in the consultation process. This process was designed to be as inclusive as possible and encourage representation from the following communities: People living with HIV/AIDS (PHAs), youth, gays and lesbians, African Nova Scotians, First Nations people, injection drug users (IDUs), health care service providers, HIV/AIDS organizations, as well as representation from various provincial government departments. This process was the result of a commitment from both community and government to work together in partnership. *A Framework for Action* outlines the findings and recommendations of this process.

The recommendations fall into six key areas:

- Prevention and Education
- Harm Reduction and Testing
- Population-Specific Action
- Community Development and Service Coordination
- Research and Funding
- Media

Many recommendations could be grouped under several of the headings, so it is important that the document be read in its entirety to get a complete picture of the HIV/AIDS needs of Nova Scotians.

Through the consultation process, participants clearly identified the need for a coordinated response to HIV/AIDS. It was recognized that good work is being done in Nova Scotia, however, to increase the impact of this work it must be coordinated and focused.

The strength of this document lies in its focus on community response. The issues have been identified in every region of the province and the strategies must also come from those communities in equal partnership with all levels and sectors of government, non-government institutions, professionals groups, and the private sector. This document should be used as a blueprint; a way to focus the enormous energy and commitment found in our communities to develop projects and programs that respond to the HIV/AIDS needs in each community.

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Introduction

The Changing Face of AIDS

In the early 1980s, gay men in the United States and large urban areas in Canada began to develop an illness that attacked the immune system. Eventually, this led to rare infections and death. Informally referred to as the Gay Plague, this illness was first named *GRID* or *Gay Related Immunodeficiency*. Over time, it was recognized that a virus caused the illness and the name of the infection was changed to *HIV* or *Human Immunodeficiency Virus*. This was the first of many changes in our understanding of HIV.

HIV and AIDS can affect anyone of any age, gender or social status.
- Provincial Consultations

As the virus continued to spread, a new shift occurred. It was no longer just the gay male community where rates of infection were increasing. Infections were documented in the heterosexual community, injection drug using (IDU) community, in prisons, and among Aboriginal people. More recently, socially and economically marginalized youth have been identified as being at high-risk, in particular young women and young, gay men.

Research conducted in the 1980s found that HIV could be transmitted through specific body fluids including tainted blood. People who had received a blood transfusion and/or blood products were encouraged to have an HIV antibody test. Many were infected before November 1985 when the Canadian Red Cross began screening the blood supply for HIV.

In Nova Scotia, rates of infection and populations at risk follow the trends observed across Canada. At this time, the majority of people living with HIV/AIDS (PHAs) in Nova Scotia are men who have sex with men (75.8%) (Nova Scotia Department of Health [NSDOH], 2000). Women are increasingly being diagnosed HIV-positive in this province. Injection drug use accounts for 9.2% of HIV infections in both men and women. Heterosexual sex accounts for 5.8% of infections (NSDOH, 2000). The Aboriginal community is beginning to document rates of infection two to five times the rate of the non-Aboriginal community (Health Canada, 2000a, 2000b).

The African Nova Scotian community is largely isolated with few clear statistics currently available. High rates of teen pregnancy indicate that some youth are not practicing safer sex. Hepatitis C outbreaks in the Eastern Health Region and correctional facilities demand a response.

With the production of new life-prolonging anti-viral medications and new combinations of treatment, the annual number of reported AIDS-related deaths has decreased dramatically from a high of 1,400 in 1994/95 to 106 in 1999 (Health Canada, 2000a). The HIV epidemic, however, continues to grow across Canada.

As more people are becoming infected with HIV and are using new drug therapies, HIV/AIDS has taken on a new face. Current issues being discussed include job re-training, the stress of living with serious, long-term drug side effects, and learning to find a renewed purpose in life.

Given these epidemiological shifts, a renewed response to HIV/AIDS in Nova Scotia was an imperative. It is anticipated that the process of developing this *Framework for Action* will result in more meaningful, relevant, and effective strategies for reducing/controlling the spread of HIV, and caring for those who are living with and/or affected by this disease.

Economic Costs

The cost of HIV/AIDS must be considered in relation to the direct medical costs of drug therapy, doctors' fees, hospital care, home care, and access to holistic therapy, as well as indirect costs. Loss of income, transportation, and the care that is provided by family members are often considered indirect costs, which contribute to the overall financial burden of HIV/AIDS.

Advances in medical treatments for HIV/AIDS have improved the life expectancy for PHAs. Many HIV infected persons utilize health care resources over a 15-year period of treatment. In the report, *"The Economic Burden of HIV/AIDS in Canada"* (Albert & Williams, 1998), it was estimated that each new HIV infection costs Canada $753,000, i.e., $153,000 in direct costs, and $600,000 in indirect costs (e.g., lost productivity).

Apart from the direct medical costs of HIV/AIDS treatments, there are very significant costs in terms of human capital - the value of people's skills, education and productivity.

Less tangible, but equally important are the loss of one's quality of life as the disease progresses, the impact on families and caregivers, the loss to the community as a whole and the additional burden placed on non-health related social agencies.

The costs of prevention programs aimed at slowing the spread of the disease must also be factored into the equation. In Nova Scotia, anonymous testing services, a toll-free information line, and needle exchange programs are a direct response to the need for prevention of HIV and other blood-borne pathogens (BBPs).

A recent evaluation of the Mainline Needle Exchange Program in Halifax concluded that between 1993-1997, this program saved the health care system approximately 11 million dollars (1997 Cdn $), which otherwise would have been spent treating new cases of HIV/AIDS (Drow, McLaren, & Skinner, 1998).

Prioritize harm reduction, health promotion and prevention for HIV/AIDS as they are more cost-effective in the long-term.
- Provincial Consultations

HIV/AIDS in Nova Scotia

According to Public Health Service records, the first official AIDS diagnosis in Nova Scotia was in 1983. Government and community-based organizations have informed Nova Scotians about HIV/AIDS-related issues and have served people with AIDS and their families since the disease first appeared. In 1982, the Gay Men's Health Association (GMHA) banded together to provide early support and health education to gay men suffering from this deadly new disease.

In 1984, the GMHA changed its name to the Metro Area Committee on AIDS, which later became AIDS Nova Scotia (ANS). Four years later, the Nova Scotia Persons with AIDS Coalition (NSPWAC) opened its doors. In 1995, ANS and NSPWAC combined resources and expertise, becoming the AIDS Coalition of Nova Scotia (ACNS).

Because of groups like the ACNS, AIDS Coalition of Cape Breton, Pictou County AIDS Coalition, Truro and Area AIDS Outreach Project, The Red Door, Church Members Assembled to Respond to AIDS (CARAS), AIDS-Link Spiritual Care, Healing Our Nations (formerly Atlantic First Nations AIDS Task Force), Mainline Needle

Exchange, and Sharp Advice Needle Exchange, people in nearly every region of Nova Scotia have, at one time or another, had access to some form of HIV/AIDS support and education. These services, however, are not equitably available and/or accessible in all regions, particularly for rural and vulnerable populations. Existing organizations have also experienced a growing demand for their services simultaneously with funding cutbacks over the last several years.

The Government of Nova Scotia has also responded to AIDS since the beginning of the crisis. In 1984, the province funded an AIDS counsellor and the *INFORM-AIDS* toll-free hotline. In 1988, the province created the *Nova Scotia AIDS Task Force* to look closely at the HIV/AIDS issues around the province. In 1989, the Task Force recommended the creation of the Nova Scotia Advisory Commission on AIDS (NSACA). The province adopted its first provincial AIDS strategy in 1993, and has enthusiastically supported its renewal through the current *Nova Scotia's Framework for Action on HIV/AIDS* (the *Framework*) process. The Department of Education prepared classroom materials for junior high and senior high school students, and made them available to all school boards.

The province also funds an anonymous HIV testing program through *Planned Parenthood Metro Clinic*, Halifax, and two needle exchange programs (*Mainline Needle Exchange* in Halifax and *Sharp Advice Needle Exchange* in Sydney). Public Health Services provides trained public health nurses to offer HIV prevention across the province, and through the *Community Health Promotion Fund*, gives grants to community-based organizations for special HIV/AIDS projects.

Overview of Consultations

At the time of the consultations there were four separate health regions in Nova Scotia: northern, eastern, western, and central. More than 200 people participated directly in the consultation process. This process was designed to be as inclusive as possible and encourage representation from the following communities: PHAs, youth, gays and lesbians, African Nova Scotians, First Nations people, IDUs, health care providers, HIV/AIDS organizations, as well as representatives from various provincial government departments. This process was the result of commitment from both community and government to work together in partnership.

Two rounds of consultations were held in each region. The first round consisted of five weeks of meetings, group discussions with staff or Board of Directors of community organizations, and interviews with communities and stakeholders in the spring of 1999. The feedback of all participants was summarized and presented in a discussion paper entitled *"Partnership in Action: Toward the Development of a Provincial HIV/AIDS Strategy for Nova Scotia."*

In the spring of 2000, all participants received a summary of the consultations for their respective regions. A second round of consultations was then conducted for verification and/or clarification of the information.

Limitations of the process: Although designed to be as inclusive as possible, not all communities were reached in the first and/or second round of consultations. Some of the planned general and group specific sessions, particularly in Central Region, were either cancelled, changed to accommodate agency's workloads, or poorly attended. Time constraints, lack of awareness of the consultation process, and scheduling difficulties appeared to be contributing factors. Other possible reasons offered were the comfort level consumers have in public forums, anonymity, transportation and location of the focus groups. Agencies serving immigrant communities cited cultural boundaries that might discourage women from attending forums open to both sexes. PHAs interviewed indicated the need for safe forums in which they felt comfortable presenting their concerns.

Regional summaries: In each region, community representatives spoke of how HIV/AIDS had impacted their communities and services. Many of the concerns raised were similar although some were more prominent in each region. An understanding of the issues specific to each region is important for the development of effective action strategies.

1. Eastern Region: Several major themes arose out of the discussions in Cape Breton. Education, access to services, the need to monitor how services are provided, and lack of response to the needs of PHAs were issues of concern. Poverty, high unemployment, and cuts in budgets and services were also issues frequently mentioned.

Many participants felt that education in schools on healthy sexuality and HIV/AIDS was not adequate and did not reach students in a meaningful way. The sexual health curriculum approved by the Department of Education was either unavailable or inconsistently used in some schools. In some cases, teachers skilled in providing HIV/AIDS and sexuality education were not consistently assigned to teach this subject and/or were prevented from providing some parts of the curriculum. Further, community-based AIDS Organizations (CBAOs), PHAs, and public health representatives are often asked to assist in teaching this information without compensation for their time and expertise.

First Nations communities spoke of the need to access traditional healing practices. Actual and/or perceived lack of confidentiality has prevented some First Nations PHAs from seeking support or treatment.

Community outreach workers are often stigmatized by the general public or other health care services (e.g., insurance companies are reluctant to insure vehicles transporting drug injection equipment). Often they are identified as gay, IDUs, and/or HIV-positive, and are not valued for their knowledge and expertise in working with marginalized populations. CBAO staff are typically "overworked and underpaid" due to a lack of resources and funding.

Poverty and lack of transportation to predominantly Halifax-based services were identified as barriers to support. Also, because of the stigma of HIV/AIDS, fear and oppression have made it difficult for PHAs to care for themselves and seek treatment from traditional service providers. PHAs desire better representation in decisions made regarding service provision and education, and to work effectively within the system.

Health care and social service providers were identified as requiring education regarding harm reduction and substance use. The need for less red tape around assessment and admission to treatment programs was also identified.

The need for physicians, nurses, and other service providers to respect the individual rights and privacy of PHAs was also discussed.

Finally, the need to coordinate services for PHAs, and for traditional service providers to work in partnership with CBAOs and street outreach programs in hard-to-reach populations was also identified.

2. Western Region: Local access to anonymous testing, and/or access to a local infectious disease clinic, and the need for better education with youth and among helping/health professionals were identified as key issues. Some participants identified concerns such as anonymity, transportation, and access to medical services, attitudes of neighbours/professionals as problems.

   Group discussions included reference to child welfare policy, homophobia, access to mental health resources for PHAs and support for family and friends of PHAs. The role of the various churches in HIV/AIDS education and support was also discussed.

   The lack of access to practical and confidential sexuality education and information to youth was a major concern. Generally, adults were considered the biggest barriers to youth in accessing practical sexual health information and services. For instance, participants indicated that some teachers are not comfortable providing some or all aspects of the sexuality curriculum, principles are not supportive, and parents and/or community members have objected to giving young people sexual health information and resources.

   The increase in homophobia, especially among youth was a major concern. Some participants suggested that their communities fear homosexuality more than AIDS.

   PHAs discussed the need for physicians to be cautious when prescribing medication to PHAs, particularly tranquilizers and pain medication in terms of side effects and other quality of life issues. PHAs, family members and support workers also expressed concern about the lack of resources available to treat and care for PHAs in their home communities, and that travel to Halifax for such services is difficult for chronically ill individuals.

   Existing health care service providers were identified as needing more awareness around the psycho-social issues related to HIV/AIDS, rather than just clinical needs.

Addiction programs often refuse PHAs because of medical complications or lack of training. PHAs complained about being referred from one service to the next, having to tell their story over again.

Respondents identified the lack of resources and under-funding of existing services to serve First Nations communities, African Nova Scotians, and the Acadian community. In addition, as a result of vulnerability to HIV infection created by poverty and single parenthood, services responsive to the specific support needs of women such as respite and chid care, were identified as a priority.

The negative influence of church doctrine and policy on prevention and education, and that the church response to HIV/AIDS changes from denomination to denomination were identified as problematic. Dialogue is needed within churches to clarify their position.

3. Northern Region: Concerns regarding education, anonymous testing, needle exchanges, youth, care for PHAs, funding structures/initiatives and research were common themes. In addition recommendations were made regarding women; distribution of condoms; relationships between parents, children and HIV/AIDS education; IDU; the church community; and the disabled.

   Information regarding the quality of condoms, proper use, and where they can be obtained needs to be available, particularly to youth was identified as a priority. It was also suggested that pharmaceutical companies could work with policy makers to secure a commitment to condom donations. A research project to study the impact of free condom provision was also recommended.

   Teaching healthy sexuality is undervalued within the education system. Parents also require support and practical training for engaging their children in discussions about safer sex and other topics.

   Increasing the availability of methadone treatment, court support programs, advocacy, and addiction services for IDUs that are open to harm reduction strategies were recommended. Accessible women-specific services were also identified as a priority.

Skill building workshops for PHAs on how to negotiate treatment and medication regimens with health care providers, especially in terms of side effects and other effects on quality of life were recommended. PHAs also indicated a need for consumer advocates. Recommendations were made about the need for legislation regarding support for PHAs returning to work, their rights as employees, and employer's obligations.

Respondents called for more substantial, less fragmented funding mechanisms. Partnership and collaborative efforts need to be acknowledged, researched, and supported by funders. Funding formulas should consider the unique issues encountered in a large region with many remote, isolated or small communities.

Establishment of an accountable funding body responsible for distribution of funds for HIV/AIDS was strongly recommended.

4. Central Region: There were a number of concerns particular to Halifax, and coordination of services among several provincially mandated organizations. Specific recommendations were made regarding medication; disability coverage; hospice and support services for PHAs; funding infrastructure; intergovernmental dialogue; the need for CBAOs to partner with health care and social services; and the impact of sexism and racism on the African Nova Scotian community, First Nations community, and other marginalized groups.

PHAs talked about the discretionary power of social service workers when determining to what benefits/services individual consumers are entitled. For instance, many PHAs expressed concern that questions about sexual orientation and how they contracted HIV appeared to be a part of a means test. PHAs also indicated that hospitalization occurs more often than is appropriate and at a much greater cost than community support services, such as hospice or supportive home care.

The need for advocates for PHAs, similar to those provided to mental health consumers was identified. It was also recommended that health and social service professionals be given training on power issues in helping relationships, and learn to use significant others as allies and resources in working with HIV-infected clients.

Funding and infrastructure concerns were common themes across the province, and some very specific recommendations came out of the central region's consultations regarding intergovernmental dialogue, funding of CBAOs, as well as how and where the funding decisions should be made. Sustainable operational funding for AIDS-specific services at the provincial level was emphasized to enable action on recommendations within the *Framework*.

It was recommended that funding for CBAOs be based on a transparent formula that incorporates both social and qualitative data and population-based, quantitative formulas, to ensure that services are responsive to the needs of communities. Partnership and coordination of services were encouraged. The creation of a "coordinating body" for all provincial services was suggested. Increased funding levels and duration were identified as a priority to ensure that programs and services are sustainable and cost-effective.

Systemic racism and sexism were identified as significant barriers to service for minorities and/or marginalized populations. Many of these organizations detailed the kind and frequency of discrimination faced by their clients. Very few such experiences, however, have been formally reported to the Nova Scotia Human Rights Commission. The majority of services to these groups are also located in Halifax, limiting access for rural populations.

Common Themes: A number of issues were common to each region and/or overlapped. Education about prevention and treatment of HIV/AIDS was the most common concern of Nova Scotians. In particular, participants identified health care professionals, employers, social service workers, and teachers as needing to have better access to up-to-date information and training. HIV/AIDS prevention education was identified as a high priority. Participants strongly advocated the need for targeted prevention initiatives that are culturally relevant, accurate and easily accessible. Poverty was identified as a barrier to prevention and adequate treatment of HIV/AIDS.

There is also a significant amount of fear in some communities regarding the education of young people about HIV/AIDS. Participants suggested that a more practical approach is necessary when teaching children and youth about healthy sexuality and HIV/AIDS.

Participants in all regions of the province requested more anonymous testing, more needle exchanges, and more HIV/AIDS specific health care services. Currently, Nova Scotia has only one anonymous testing site, located in Metro Halifax. There are also only two needle exchanges; one in Metro Halifax, the other in Sydney. In rural communities, participants talked about lack of privacy and being too visible in the communities in which they live. Some IDUs travel to Halifax for needle exchange because it is difficult for them to access needles locally.

In urban centers, people felt that testing and needle exchanges were not reaching "hidden" populations. Participants stressed the need for more street workers and outreach services. They indicated that these workers are more successful in working with hard-to-reach populations than traditional health care workers. Outreach workers are also more effective in connecting hard-to-reach groups with traditional health care services in both urban and rural communities.

PHAs said they want to be involved in decisions about policy and procedure, but many are uncomfortable expressing their opinions and concerns in meetings with professionals and government bureaucrats. PHAs were concerned about privacy, access to health care services, lack of financial support, limitations of third party insurance plans to cover care and medication, rigid opinions of health care and social service staff, and prejudice. PHAs identified issues around confidentiality and privacy as being of critical importance, and that guidelines should be in place and monitored for those who have access to medical information.

Racism, sexism, and other forms of prejudice were identified as important issues in many communities. Participants from the gay and lesbian community, women, Acadian community, the African Nova Scotian, and First Nations communities repeatedly identified barriers in accessing services and information. In several communities, gay and lesbian PHAs, volunteers, and others talked about experiencing job loss, isolation, and sometimes violence when they openly expressed their needs, volunteered to offer peer support, or attempted to access services.

The inability to access region-specific HIV/AIDS statistics, such as the number of reported infections and the number of PHAs in need of care and support was identified in every region.

In some regions, participants expressed a concern that the number of HIV infections are under reported in provincial statistics, and therefore, they do not have accurate information that would help with development of prevention initiatives. It was suggested that better communication is needed between street workers, traditional health care workers, and researchers if accurate information is to be collected, and the big picture addressed.

Every region stressed the need for a more coordinated approach to HIV/AIDS issues such as improving communication between federal and provincial departments of education, health, social services and corrections. It was recommended that HIV/AIDS be addressed through a broad, multisectoral approach to encourage provincial government ministers to involve all departments in a coordinated response.

There needs to be discussion at the cabinet level, between criminal justice, health, education, social services [and CBAOs] regarding the development of policy and a coordinated approach.
- Provincial Consultations

Community organizations identified funding cutbacks as an issue that will have critical impact on PHAs and the level of services that can be offered to the community as a whole. As stated by one participant, *"programs waste valuable outreach, health promotion, advocacy, and intervention time doing fundraising. The process for funding is cumbersome, not responsive to community needs, linear, and too process-focused."*

The Framework for Action

How to use this document: Nova Scotia's renewed *Framework for Action on HIV/AIDS* outlines a set of recommendations intended to direct and focus the work of community-based AIDS organizations (CBAOs), government departments, educators, health professionals and individuals with a commitment to action. The development and implementation of both short and long-term strategies can evolve through various community and government mechanisms.

A structure needs to be established to take leadership in facilitating the implementation of these recommendations. For instance, designates from the network of CBAOs throughout Nova Scotia and/or the Provincial HIV/AIDS Strategy Steering Committee could conduct annual meetings or other forums wherein community and government representatives could meet to evaluate progress on addressing the recommendations in the *Framework*, develop or review action strategies, and foster the development of partnerships. The Provincial HIV/AIDS Strategy Steering Committee may also continue to meet on a regular basis to brainstorm and monitor action strategies, and develop an evaluation plan to monitor progress.

In addition, the Interdepartmental AIDS Liaison Committee (IALC) see definition in glossary) will continue to be responsible for facilitating communication and coordination of action strategies with CBAOs, the NSACA, and all Nova Scotia government departments. Finally, monitoring and reporting on progress with the *Framework* through an annual report card is essential. This report card will be sent to government and community stakeholders, and will provide recommendations for action and what partners should be involved for each. An update on process with the *Framework* will also be included in the NSACA's annual report.

Recommendations

The findings and recommendations of the consultation process fall into six key areas:

- Prevention and Education
- Harm Reduction and Testing
- Population Specific Action
- Community Development and Service Coordination
- Research and Funding
- Media

Many recommendations could be grouped under several of these areas, so it is important that the document be read in its entirety to get a complete picture of the needs of Nova Scotians.

Prevention and Education

Participants discussed issues related to the public, education for children and youth through the schools, and education for health care professionals, social service workers and support staff in hospitals, labs, medical/dental offices. Participants indicated that school teachers who provide the sexual health components of the curriculum fear being reprimanded and/or sued by parents, principals, and school boards, accused of promoting sex, pornography, and bad language for using videos or resources containing "street language" that students understand. Parents who are opposed to the teaching of healthy sexuality are often the most verbal. The need for teachers to be encouraged, and protected to be forthright and creative in presenting material was strongly emphasized. Questions were raised concerning the role of the boards, principals and teachers' unions regarding this issue.

Health care professionals were acknowledged as over-burdened and in some communities, scarce. It was widely recommended that additional training be provided for health care workers and support staff regarding the needs of PHAs, and the obligations of staff regarding confidentiality and privacy of medical information.

Education System

Teaching sexual health needs to be supported and prioritized. We need to earmark good teachers.
- Provincial Consultations

1. Provide accurate and up-to-date information about the relationship between sex and sexuality and HIV/AIDS to enable educators to communicate more effectively with children and youth.

2. Deliver a comprehensive, consistent, healthy sexuality curriculum (including HIV/AIDS, sexism, racism, and homophobia within the context of healthy living) in every school in Nova Scotia. Successful peer education models should be supported.

3. Provide ongoing support and training for teachers who are given the responsibility for providing the sexual health components of the curriculum. Teaching the sexual health curriculum should be identified as a priority within the education system, and appropriate resources should be provided.

4. Make French HIV/AIDS resources available to educators. The New Brunswick Department of Education may be able to recommend resources.

Health Care Professionals

Professionals need training around harm reduction and the relationship with HIV/AIDS.
- Provincial Consultations

5. Provide peer-driven education to health care and other service providers (e.g., physicians, nurses, home care workers, social workers) and enhance education for students of health professions about HIV/AIDS-related issues such as harm reduction, sexuality, homophobia and populations at risk.

6. Provide training and resources to physicians and support staff regarding ethical and legal obligations around confidentiality and disclosure.

Parents need to be educated regarding the need for healthy sexuality education for their children, and how to talk to children about sex.
- Provincial Consultations

Public

7. Make appropriate resources available for parents and community educators to talk to children and youth about HIV/AIDS and sexuality.

8. Create a public awareness campaign focusing on critical HIV/AIDS issues for all Nova Scotians.

9. Encourage public involvement in HIV/AIDS education and community activities (e.g., AIDS walks).

Harm Reduction and Testing

Harm reduction strategies reduce the effects of potentially harmful behaviours often by connecting marginalized populations to HIV/AIDS-related services such as needle exchanges and condom distribution, and supporting physical, emotional, and social needs through public health services and community organizations.

Harm reduction strategies seek to reduce the likelihood that IDUs will contract or transmit HIV, HBV, and/or HCV and other infections, overdose on drugs of unknown potency or purity, or otherwise harm themselves or other members of the general public. The need to foster a common understanding of harm reduction between CBAOs and addiction services, and the kinds of services that fall under this approach was identified by participants.

There needs to be better access to a continuum of harm reduction service and recognition for the value of outreach and community workers.
- Provincial Consultations

Increased access to needle exchanges, methadone programs, and anonymous testing services; and privacy, safety and confidentiality for those using these service were prominent in these discussions, particularly for vulnerable and/or hidden populations. Barriers impeding access and use of condoms (e.g., cost, confidentiality) was identified as an urgent priority. Many community representatives spoke of the potential role of pharmaceutical companies in harm reduction strategies by providing low-cost or no-cost condoms to the province.

General

11. Encourage open and ongoing discussion regarding harm reduction strategies/approaches between addiction services and CBAOs. The goal of this discussion is to work toward a common understanding of harm reduction.

Condoms

12. Make condoms more widely and discreetly available to youth by providing them, free, through youth and community centres, schools, Planned Parenthood, and similar venues.

13. Make condoms more widely and discreetly available to the general public by providing them, free, through social services agencies, public health nurses, needle exchange sites, and anonymous testing sites.

14. Explore the possibility of bulk purchasing to reduce condom costs to agencies.

Needle exchanges need to be available all over the province, accessible to communities in all regions. **- Provincial Consultations**

Needle Exchanges

15. Assure province-wide access to clean needles.

16. Encourage/support peer-based delivery of needle exchange programs.

Methadone Program

17. Provide a widely accessible continuum of methadone services throughout Nova Scotia based on a harm reduction model.

18. Increase access to methadone programs within the correctional system province-wide and continue seamless provision of methadone upon release.

Testing

19. Establish a network of anonymous testing sites across the province. Testing sites should be chosen based on ability to provide counselling, referrals, confidentiality and accessibility.

Population-Specific Action

African Nova Scotians

Provincial and national surveillance systems do not provide statistics on the number of African Nova Scotians/Canadians with HIV/AIDS. However, systemic racism and discrimination have created social and economic inequities (e.g., poverty, unemployment) that increase the risk of engaging in high-risk behaviour.

A province-wide needs assessment conducted by the former Black Outreach Project (B.O.P.) (Bernard,1993), concluded that racism had created significant barriers to the development and delivery of HIV/AIDS related programs and services to African Nova Scotians. Concerns identified by the B.O.P. in 1993, and African Nova Scotian participants in the consultations in 1999-2000 regarding prevention and treatment services for their communities were: resource constraints, racially and culturally insensitive programming, lack of funding for targeted programming, and exclusion from health care and policy discussion.

There is a stigma attached to HIV/AIDS in the African Nova Scotian community. It's a no-talk issue denied by family members or identified as something else.
- Provincial Consultations

Respondents from the African Nova Scotian community talked specifically about the need for Afro-centric services and CBAOs that are safe, provide "black friendly" resource materials, and have staff from the African Nova Scotian community. In general, community representatives indicated that existing CBAOs do not address the needs of African Nova Scotians.

Church and spirituality are significant in the African Nova Scotian community. It was suggested that religious leaders could play an important role in education and awareness, although current interdenominational forums include few African Nova Scotian church representatives. In addition, it was identified that little, if any, research has been pursued in regarding HIV/AIDS and African Canadians, and/or African Nova Scotians. As stated by one respondent, *"black people want to be talked to, not about."*

20. Include African Nova Scotians in all discussions and decisions concerning every aspect of HIV/AIDS strategy development to ensure issues and barriers faced by African Nova Scotian communities are addressed.

21. Support community organizations to develop culturally and socially-specific HIV/AIDS resources, training, education, and treatment programs.

22. Develop a provincial epidemiological reporting framework that captures HIV/AIDS incidence and prevalence in the African Nova Scotian population.

23. Make HIV/AIDS-related community development, prevention, and treatment programs, including anonymous testing, more accessible to African-Nova Scotians.

24. Explore partnerships between the Black Educators' Association, the Department of Education, the Human Rights Commission, and others with respect to developing culturally relevant curricula for African Nova Scotian students.

Correctional Institutions

The number of inmates with HIV/AIDS in provincial and federal prisons is on the rise (Jürgens, 1996) and as a result, health care costs are expected to rise dramatically over the next few years. In addition, the prevalence of HIV infection among IDUs outside of prisons is growing at an alarming rate, and because many IDUs spend years of their lives in provincial and federal prisons, it is anticipated that the number of inmates with HIV/AIDS will continue to grow. Inmates who are IDUs are likely to continue injecting in prisons and share injection equipment, creating a high risk of transmission of BBPs between inmates and later, upon release, to the general public.

Current action to address the spread of HIV and other BBPs in provincial correctional institutions include a pilot methadone project (implemented December 1999), Hepatitis A and B immunization, and the provision of condoms and dental dams to inmates upon request. Further action, however, is required. The health of inmates can be enhanced by expanding appropriate prevention and harm reduction policies, and the general public can be protected from an increased risk of HIV and hepatitis transmission, and the province can fulfill its ethical and legal responsibility to all Nova Scotians.

25. Implement existing recommendations for harm reduction strategies for both inmates and training for staff.

26. Provide ongoing sensitivity training for corrections officers in consultation with the community, CBAOs, public health, the HIV/AIDS clinic and drug dependency services and community organizations.

27. Provide ongoing training, particularly concerning universal precautions, for corrections officers.

28. Offer ongoing, peer-based HIV/AIDS prevention programs in every provincial institution, including youth facilities.

First Nations

First Nations people are over represented in terms of the risk factors that can result in HIV infection and are disproportionately affected by HIV. In Canada, the HIV risk to First Nations is two to five times higher than the rest of the population (Health Canada, 2000a, 2000b). According to Health Canada (2000b), although Aboriginal people represent 2.4% of reported AIDS cases where ethnicity was known, the annual proportion of cases in this population increased from 1% before 1990 to 15% in 1999. This is in sharp contrast to the decreasing rate of overall reported AIDS cases. In addition, the incidence of new HIV infections from provinces that report ethnicity, including Nova Scotia, indicate an increase in the proportion of reported cases attributed to Aboriginal people from 19.4% in 1998 to 24.8% in 1999 (Health Canada, 2000b).

First Nations (like African Nova Scotian communities) spoke about the influence of colonialism and the loss of land, family and heritage. This has contributed to the likelihood that members of these communities will experience the conditions that increase vulnerability to HIV/AIDS, such as poverty, racism, alienation, substance use, unsafe sex, marginalization, unemployment and limited access to prevention, health promotion, and treatment services. Both communities pointed to both federal and provincial reports that echoed these concerns.

29. Encourage and promote First Nations representation on the NSACA so strategies are developed with consideration to traditional beliefs and ways of living.

30. Make traditional healing methods more accessible to First Nations PHAs.

31. Remove barriers to First Nations for accessing services (e.g., funded home care, transportation, and medication for First Nations PHAs).

32. Foster discussions between First Nations, federal and provincial health care funding structures specifically relating to HIV/AIDS funding, jurisdictions, and programming working with First Nations.

33. Develop a provincial epidemiological reporting framework with First Nations that captures HIV/AIDS incidence and prevalence in the First Nations Communities.

34. Make anonymous testing and needle exchange more accessible to First Nations communities.

First Nations need to be involved in discussions at the provincial level, addressing the role socio-economic factors play in high risk behaviour for HIV/AIDS in their communities.
- Provincial Consultations

Gays and Lesbians

Men who have sex with men make up the largest proportion of HIV/AIDS cases in Nova Scotia and throughout Canada (Health Canada, 2000a, 2000b; NSDoH, 1998). Gay youth are being infected at an increasing rate and are more difficult to reach through traditional or mainstream prevention programs (Campbell, 1998; Health Canada, 1998).

Gay and lesbian participants in the consultations, as well as representatives of sex trade workers, talked about the impact of sexism on their ability to access services, be reached by harm reduction and prevention strategies, and on their motivation to seek traditional treatment, respite and/or home care services.

The discussion paper "*Gay and Lesbian Legal Issues and HIV/AIDS*" (Vassal, Fisher, Jürgens, & Hughes, 1997), indicated that discrimination against gays and lesbians was pervasive in Canadian society. This discrimination and homophobia has negatively affected every aspect of their lives, such as employment, housing, and social and family relationships.

Discrimination and homophobia have also negatively impacted a person's ability to protect his or herself from HIV infection, the effectiveness of HIV/AIDS prevention programs, and the provision of care, treatment, and support to PHAs (Vassal et al., 1997). For instance, the school system's reluctance to provide positive education about homosexuality has increased the vulnerability of young gay men to contracting HIV. In addition, the fear of being labeled a homosexual has discouraged and/or delayed some people from seeking care, treatment or support.

35. Address issues of homophobia and its connection to HIV/AIDS within health sexuality programs in school.

36. Ensure that the education system understands and responds to the issues of gay and lesbian youth, and provides a safe environment for these youth.

37. Establish and fund an infrastructure that addresses gay men's health issues from a broad perspective that includes HIV/AIDS.

37. Acknowledge the contributions the gay community has made in increasing knowledge about HIV/AIDS.

People Living with HIV/AIDS (PHAs)

Although some PHAs talked about the excellent care and support received from individual doctors, nurses, AIDS workers, volunteers, and family/friends, more often than not they are impoverished, marginalized, harassed and discriminated against by third party funders, landlords, employers, and mainstream health care and social service providers.

The requirements the system imposes on consumers of HIV/AIDS support and treatment services (such as access to medications and health care, disability benefits and drug cards, financial support for food and housing, transportation and home care) are often difficult for PHAs to meet given their health status, length of illness and number of supports they have in place.

Existing services are also overburdened. Physicians in rural areas sometimes refuse to treat PHAs. There are also many barriers to adequate access to treatment such as third party insurance funding; lengthy waiting lists; misinformed or judgmental health care providers, home care or social services' staff; physician fee structures; and the lack of funding for some medical and health care services in all areas of Nova Scotia. PHAs are often forced to leave their communities, and sometimes, the province to receive necessary services.

Quality of life issues with respect to medications dominated focus group discussions. Many PHAs encountered apathy among drug companies and health care professionals when they gave feedback on the side effects of medications. PHAs talked about having to work hard to find some common ground with their physicians, allowing them to live a more active life by addressing concerns about the side effects of drugs.

Negotiating what medications they can or will take, how they will access them, and affording all the necessary medications is often overwhelming. Further, with "clinical/biological" aspects of treatment dominating the health care industry's focus on HIV/AIDS, the emotional/psychological effects are often minimized or ignored.

Also, given changes in anti-retroviral drug treatment over the past ten years, many PHAs are able to return to work. Participants talked about the need for PHAs to return to disability if they encounter relapses (temporary or long-term), the need for rest periods, coverage of medication, and the ability of employers to accommodate these concerns.

Concern was also expressed about the lack of funding for alternative treatments thorough the current health care fee structure. Mainstream health care providers have sole access to the resources, and alternative approaches to pain management like reflexology, massage, or acupuncture are often not recommended or covered by MSI or third party funders. Pills are offered as the only pain management option.

Advocacy and empowerment are important for consumers of healthcare services, in particular PHAs.
- Provincial Consultations

39. Address underlying issues that enable discrimination toward PHAs in the workplace and establish policies that safeguard against such discrimination.

40. Establish enforceable laws protecting PHAs from discrimination in the workplace.

41. Address barriers in accessing care, treatment and support for PHAs who are also IDUs and/or have mental health problems.

42. Address barriers in accessing care, treatment and support for PHAs who live outside HRM (e.g., travelling clinic, telemedicine, transportation services).

43. Ensure that a special consideration of HIV disease is included in policies and guidelines addressing disabilities.

44. Ensure Mental Health Services, especially designated patient/client advocates, are aware of the special needs of PHAs with mental health problems.

45. Establish support networks for families and caregivers of PHAs so they may access ongoing support and assistance.

46. Consult with CBAOs and PHAs both in addressing, developing, and setting provincial standards and policies concerning third party funders and in providing seamless funding with respect to provincial services.

47. Educate both providers and recipients about standards and policies concerning third party funders and about any appeal processes in place.

48. Require community, municipal, provincial, and special program service workers to take sensitivity training relating to working with PHAs.

49. Increase home care service provision to PHAs while also making these services more accessible.

50. Increase affordable housing and other home support options for PHAs.

51. Increase hospice and palliative care services to PHAs while also making these services more accessible.

52. Establish broadly accessible programs that focus on fitness for PHAs (e.g., muscle development).

53. Encourage physicians to recognize patient support and advocacy needs by fostering, accepting, and encouraging significant others, supportive individuals, care givers, and advocates to participate in PHAs' treatment and care plans.

54. Make HIV/AIDS medications more accessible province-wide (e.g., through depots or specific physicians).

There is a need for seamless access to services, not bouncing around consumers. Cooperation needs to be encouraged between different health services and other resources.
- Provincial Consultations

55. Ensure provincial coverage of all federally approved HIV/AIDS medications.

56. Reassess provincial caps placed on HIV/AIDS medications every six months as drug therapy and associated costs are constantly changing.

57. Ensure PHAs either presently employed or returning to work have access to provincial pharmacare drug cards if employers and/or private drug plans are inadequate or not available.

58. Explore possibility of designating an ombudsperson for PHAs.

Women

Recent statistics show an increased incidence of new HIV infections among women (Health Canada, 2000a, 2000b), and the need for women specific action was emphasized in the consultations. Participants recommended that current services addressing women's health issues be utilized to provide HIV testing, counselling, education and prevention services (such as mammography vans, family resource centers, women's wellness centers, and pre-natal classes). Poverty was identified as a key factor in increasing women's risk of HIV infection. The relationship between the factors that increase women's vulnerability to abusive relationships and contracting HIV/AIDS needs to be explored further and appropriate action strategies implemented. Respondents indicated that a number of issues related to women and HIV/AIDS have already been identified by the research community that require immediate action.

There is a marked increase in infections among women. Women need to be targeted... using existing services for education and testing.
- Provincial Consultations

59. Increase HIV/AIDS prevention strategies targeted to women within existing women's services (e.g., because HIV/AIDS can be transmitted *in utero*, increase education in pre-natal forums).

60. Conduct gender-specific clinical drug trials concerning both medication dosages and their side effects for HIV-positive women.

61. Attach services for women with HIV/AIDS to existing women's and family services in the community, and where possible, bring these services to the home.

62. Increase the scope of research concerning women and HIV/AIDS so it will include issues concerning single parenting, poverty, self-esteem, and high-risk behaviours.

Youth

National statistics indicate an increasing rate of HIV/AIDS in young people (Health Canada, 2000a, 2000b). In Canada, the estimated median age of infection is 23 years. Participants in the consultations expressed concern about the lack of resources specific to youth services, uncoordinated and intermittent funding, and a failure to recognize the effectiveness of employing prevention and harm reduction strategies to reach youth.

According to the *"Nova Scotia Sexual Health Needs and Resources Assessment: Technical Report"* (Planned Parenthood Nova Scotia & NSDoH, 1996), the failure to support youth in dealing with their sexuality has resulted in a high incidence of pregnancies, abortions, and sexually transmitted infections, including HIV/AIDS. The report also states that the unfounded fear that providing young people with knowledge and resources will increase their sexual activity is preventing them from the knowledge, attitudes and services that can protect them from negative outcomes of sexual experience.

Education needs to be offered to youth on a practical level regarding safe sex, e.g., what size condom do I get? Where do I get them?
- Provincial Consultations

63. Make youth sexuality an urgent public health issue and acknowledge the relationship between HIV/AIDS and high-risk sexual behaviours.

64. Increase the scope of research to encompass the concerns of specific youth populations.

65. Provide youth with practical, accessible information regarding safer sex.

Community Development and Service Coordination

Community development continues to be the cornerstone of HIV/AIDS work. Much of what has been achieved in reducing the spread of HIV and supporting individuals living with HIV/AIDS, has been accomplished by non-profit organizations, community-groups, and volunteers. Nova Scotia is fortunate to have a variety of skilled individuals and services dedicated to HIV/AIDS issues, albeit most are located in Metro Halifax.

We need consumer-focused services provided by professionals who understand community development.
- Provincial Consultations

Historical documentation and discussions with CBAOs, however, suggest that conflict and competing interests - as a result of funding cutbacks and an amalgamation of CBAO budgets - created barriers to partnership building and collaboration. CBAOs feared losing funding and resources, particularly those providing services to gay men and other marginalized populations.

Also, as previously indicated, PHAs expressed dissatisfaction with health and community services that are underfunded, uncoordinated, and/or system-focused, rather than focused on the needs of consumers. Services are also difficult to access by marginalized populations and those living in rural areas of the province.

To increase the impact and effectiveness of HIV/AIDS programs and services of CBAOs and that of other sectors, programs and policies must be coordinated and responsive to the needs of communities. Increased sustainability and accessibility of programs and services both locally and provincially are high priorities. Partnership and intersectoral collaboration must be enhanced to manage the complexities of HIV both competently and compassionately.

66. Shift from the medicalization of HIV/AIDS to more consumer-focused services provided by professionals who respect both community development and the need for community ownership of HIV/AIDS issues.

67. Increase the involvement of professional, spiritual care organizations (e.g., chaplaincy services) that provide direct care and support services to the HIV/AIDS community.

Why are [PHA's] dying only in care of the state? What is the role of community, family, churches...? The role of individual churches and pastors was acknowledged as the key to getting support and change [for PHAs].
- Provincial Consultations

68. Promote and encourage the on-going work of compassionate churches and faith groups who provide safe and supportive communities for PHAs and their loved ones.

69. Encourage open communication between faith communities and CBAOs in regard to the significant role that churches can have in HIV/AIDS prevention and support services.

70. Establish a Nova Scotia AIDS Network mandated to hold annual conferences.

71. Coordinate health and community/social services for PHAs and develop guidelines for case management while ensuring seamless access to these services province wide.

72. Facilitate the development of partnership and sharing of expertise among CBAOs to enhance service and program delivery.

73. Foster a coordinated approach among policy makers within a variety of sectors to develop policies and programs that address the broad factors that increase vulnerability to HIV infection, and ensures sufficient access to services for PHAs.

Research and Funding

Improving knowledge and understanding of HIV/AIDS and of the factors that increase risk of infection is key to the fight against AIDS. Basic science, clinical, epidemiological, and social science research, including community-based initiatives are equally necessary to support the development of effective HIV/AIDS programs and polices. Partnerships between communities and "professional" researchers within universities/colleges and hospitals should be reinforced. CBAOs and individuals must be supported in developing the necessary skills to define research priorities and carry-out the research, as full and equal partners in research initiatives.

As indicated in *"The Economic Burden of HIV/AIDS in Canada"* (Albert & Williams, 1998), the economic incentive for increased funding in all types of HIV/AIDS research, prevention, and education initiatives is strong. As stated in this report, *"investing in well-targeted prevention interventions that have strong links to a well-structured surveillance network could contribute to achieving effective epidemic control and savings in the order of some $4 billion by 2001"* (Albert & Williams, p. 8).

Effective needs-based prevention strategies aimed at reducing new HIV infections in vulnerable populations and improving scientific and social research, have the greatest potential to reduce both the direct medical costs and indirect costs (lost quality of life, productivity) of HIV/AIDS.

We need to support communities in development of expertise capacity building on how to research, critique research requests, and identify what kind of research needs to happen (social, quantitative, or qualitative).
- Provincial Consultations

Research

74. Support rural communities in developing expertise in identifying and conducting the types of research they most need - social, quantitative, or qualitative - and in learning to critique research requests.

75. Augment existing quantitative data with social and qualitative research for IDUs.

76. Actively recruit university professors and graduate students to participate in HIV/AIDS-related research.

77. Communicate to federal and provincial authorities the need for policy changes relating to collecting and accessing race-related statistics on HIV/AIDS.

78. Find ways to track services and create partnerships with organizations that have access to targeted high-risk populations then collect viable social statistics through those partnerships that will support funding to enhance existing services to these populations.

Funding

79. Provide and maintain youth wellness centers province-wide.

80. Increase funding to teen health centres and Planned Parenthood clinics so they may remain open year-round.

81. Increase funding to CBAOs province-wide so their potential to contribute to policy, prevention, and other priority areas can be enhanced.

82. Compensate CBAOs, PHAs, and other individuals who provide HIV/AIDS-related educational services to schools.

The provincial government could designate a party authorized to distribute funds earmarked specifically for HIV/AIDS.
- Provincial Consultations

83. Base federal transfer payments and other federal funds earmarked for HIV/AIDS on long-term consumer-focused priorities and community-based needs rather than on short-term federal priorities and target populations.

84. Designate a body to equitably distribute funds earmarked for HIV/AIDS community programming, and do so in conjunction with a consumer review committee that considers both rural and urban Nova Scotia's broad service needs.

85. Explore new funding approaches to CBAOs to maximize sustainability of programs and services.

86. Encourage funding partnerships at all levels of government for HIV/AIDS issues.

87. Allow for increased flexibility in provincial social assistance plans so they may adjust to accommodate inflation, the individual needs of PHAs, and the cost of a phone.

88. Fund an independent health consumers' advocate, coordinator, or ombudsperson to represent the needs and concerns of PHAs.

89. Approve and implement the existing draft policy regarding children in care who have infectious diseases so issues concerning testing, informed consent, and disclosure will be addressed. Provide HIV/AIDS education to child welfare staff and foster parents throughout the province.

Media

The media's portrayal of prevention and awareness initiatives within particular target populations (IDUs, youth) and its responsibilities in terms of how stories related to HIV/AIDS are covered was identified as a concern by consultation participants.

We need to encourage the media to focus on the positive things happening around HIV/AIDS.
- Provincial Consultations

Participants indicated that there is too much ethnocentricity in mainstream media, and the coverage of HIV/AIDS issues are often sensationalized and/or stigmatize certain groups. Recommendations focused on the need for the media to become a greater resource in informing communities about HIV/AIDS, and to address HIV/AIDS in a more positive manner.

90. Work with the media to address the sensationalized coverage of HIV/AIDS issues in general and in particular, of PHAs.

91. Provide the media with opportunities to positively address HIV/AIDS issues (e.g., medical breakthroughs, stories of courage).

92. Increase the sensitivity of media staff with respect to racism, sexism, homophobia, and HIV/AIDS.

Next Steps

While much has been accomplished in addressing HIV/AIDS in Nova Scotia, the consultation process identified significant gaps and barriers to progress in reducing the spread of HIV and other blood-borne pathogens, and in providing care, treatment, and support to those living with HIV/AIDS. The Provincial HIV/AIDS Strategy Steering Committee strongly encourages all who read this document, particularly community-based AIDS organizations (CBAOs) and government decision makers to commit to collaborative action between and within their areas of influence.

As previously indicated, the development and implementation of short and long term action strategies can evolve through a variety of government and community mechanisms such as annual community forums, the HIV/AIDS Strategy Steering Committee, the Interdepartmental AIDS Liaison Committee, and the Nova Scotia Advisory Commission on AIDS (NSACA). Ongoing monitoring and evaluation of all initiatives will be key activities in working with the *Framework*.

A structure must be established to facilitate the development and implementation of strategies to address the recommendations. The Steering Committee proposes that an *"HIV/AIDS Framework for Action Steering Committee"* be struck to continue the process of enabling and supporting communities to have a meaningful role in HIV/AIDS work in Nova Scotia, to provide direction for the development of innovative models for action on the recommendations, and monitor progress within the *Framework*. Membership would consist of representatives from the Department of Health, the NSACA, CBAOs, and minority and marginalized populations.

The Framework for Action Committee will facilitate the creation of several *intersectoral working groups* consisting of individuals from key government departments and community representatives to develop and implement strategies within their specific area of interest and influence. NSACA in its role of government and community liaison, would facilitate collaborative action on the recommendations and act as secretariat for the committee and individual working groups. The working groups would report to and receive direction from the Framework for Action Committee.

The Framework for Action Committee will also ask government decision makers to recognize the HIV/AIDS concerns identified by Nova Scotians and commit to supporting initiatives that respond to the specific needs in each community. Progress in gaining the support of key decision makers will be monitored by this Committee.

Because the recommendations evolved through community consultation, it is imperative that communities are supported and enabled to have a primary role in the development and implementation of strategies. Moreover, the Framework for Action Committee must strongly encourage the participation of specific populations mentioned in this document in developing strategies for carrying out actions related to the recommendations concerning their members. This will be a challenge given that these populations are often marginalized and hard-to-reach.

The blueprint for HIV/AIDS work in Nova Scotia has been provided. It is time for all partners to focus their energy and commitment to create initiatives that will effectively respond to the needs and recommendations of Nova Scotians.

Glossary

Acquired Immunodeficiency Syndrome (AIDS)

The weakening of the body's immune system by HIV (see definition, below) which permits opportunistic, life-threatening infections to develop. Typical infections include pneumonia, neurological disease, wasting, and cancer, particularly Kaposis sarcoma.

Community-based AIDS Organizations (CBAOs)

Non-profit organizations that provide information and education to people with HIV/AIDS (PHAs) and the general public, and who assist PHAs with life skills development, financial planning, housing, and care and support.

Harm Reduction Practices

An approach to reduce the spread of HIV/AIDS by incorporating a range of strategies. Harm reduction practices reduce the effects of potentially harmful behaviours, often by connecting marginalized populations to HIV/AIDS-related services such as needle exchanges, condom distribution, and supporting physical, emotional and social needs through public health services and community organizations.

Human Immunodeficiency Virus (HIV)

HIV is the virus that causes AIDS. HIV infection occurs through exposure to infected blood or to bodily fluids in sufficient quantities. It may be transmitted through unprotected vaginal or anal sex (and to a lesser degree, oral sex) with an infected partner, sharing contaminated needles, receiving contaminated blood and blood products, getting injured by a contaminated needle, and giving birth and breast feeding where the mother is infected with HIV.

Interdepartmental AIDS Liaison Committee (IALC)

Created in April 1994, IALC's mandate is to facilitate communication between Nova Scotia government departments, the Nova Scotia Advisory Commission on AIDS (NSACA) and CBAOs. It has representatives from the following departments: Health, Justice, Labour, Education, and Human Resources, Community Services, and the Human Rights Commission.

Methadone

A synthetic drug used as a substitute narcotic in the treatment of heroin addiction.

Needle Exchanges

Facilities that enable people who use injection drugs to exchange used needles for new ones.

Nova Scotia Advisory Commission on AIDS (NSACA)

Formed in 1988, the NSACA advises the government on current and emerging HIV/AIDS issues, works with communities, agencies, and government representatives to support new initiatives, develops and revises policies, and provides a resource center for the Commission, provincial government, AIDS organizations, and students doing research.

People Living with HIV/AIDS (PHAs)

Individuals who are infected and living with HIV at any stage of infection, i.e., from the asymptomatic period to the development of AIDS.

Universal Precautions

Universally applied blood and bodily fluid precautions used to minimize the risk of exposure to blood and body fluids that may be infectious.

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Appendix

Provincial HIV/AIDS Strategy Steering Committee

Members of the Provincial HIV/AIDS Strategy Steering Committee represented the following community and government organizations:

- AIDS Coalition of Cape Breton
- AIDS Coalition of Nova Scotia
- AIDS-Link Spiritual Care
- Central Region Drug Dependency Services
- Healing Our Nations
- Health Canada
- Infectious Disease Clinic, QEII Health Sciences Centre
- Mainline Needle Exchange
- Nova Scotia Advisory Commission on AIDS
- Nova Scotia Department of Health
- Planned Parenthood Metro Clinic
- Western Region Public Health Services